SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Individual Forms	SERFF Tr Num: CVKS-127622115	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 49763
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Jennifer Simms	Disposition Date: 10/12/2011
	Date Submitted: 09/12/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 11/01/2011		Implementation Date:

State Filing Description:

General Information

Project Name: Application & Rider	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact:	Filing Status Changed: 10/12/2011
	State Status Changed: 10/12/2011
Deemer Date:	Created By: Jennifer Simms
Submitted By: Jennifer Simms	Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

Rider to accommodate new product line that provides incentives for participating in wellness activities; and new application for Individual products.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Jennifer Simms, Regulatory Compliance Analyst
8320 Ward Parkway
Kansas City, MO 64114

jesimms@cvty.com
866-795-3995 [Phone] 4539 [Ext]
816-460-4695 [FAX]

Filing Company Information

Coventry Health and Life Insurance Company	CoCode: 81973	State of Domicile: Delaware
8320 Ward Parkway	Group Code: 1137	Company Type: LAH
Kansas City, MO 64114	Group Name: Coventry Health Care	State ID Number:
(866) 795-3995 ext. 4539[Phone]	FEIN Number: 75-1296086	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	2 forms @ $50/ea.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	$100.00	09/12/2011	51486101

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/12/2011	10/12/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/05/2011	10/05/2011	Jennifer Simms	10/06/2011	10/06/2011
Pending Industry Response	Rosalind Minor	09/30/2011	09/30/2011	Jennifer Simms	10/05/2011	10/05/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Cover letter 2011 09 12	Note To Reviewer	Jennifer Simms	09/12/2011	09/12/2011

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Disposition

Disposition Date: 10/12/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Fund Rider cover 2011 09 12	Approved-Closed	Yes
Form *(revised)*	Fund Rider	Approved-Closed	Yes
Form	Fund Rider	Replaced	Yes
Form	Application for Coverage	Approved-Closed	Yes

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/05/2011
Submitted Date	10/05/2011
Respond By Date	

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Fund Rider, CHL-ALL-RID-09.11 (Form)

Comment: I need a little more information on the fund. Who contributes to the fund? Is it the insured and/or insurance company? Is the fund matched by the insurance company? Is there a tax deduction for the fund? If so, for the insured or the insurance company?

Thank you for your assistance.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/06/2011
Submitted Date	10/06/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: The "fund" is contributed by Coventry based on the product purchased or "chosen" by the applicant. When the member chooses to participate in a wellness activity the designated dollar amounts for that activity will be deposited by Coventry into the "fund". The member can use that money to offset their deductible.

Related Objection 1

Applies To:

- Fund Rider, CHL-ALL-RID-09.11 (Form)

Comment:

I need a little more information on the fund. Who contributes to the fund? Is it the insured and/or insurance company? Is the fund matched by the insurance company? Is there a tax deduction for the fund? If so, for the insured or the insurance company?

Thank you for your assistance.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Jennifer Simms

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/30/2011
Submitted Date	09/30/2011
Respond By Date	10/28/2011

Dear Jennifer Simms,

This will acknowledge receipt of the captioned filing.

Objection 1

- Fund Rider, ALL-RID-09.11 (Form)

Comment:

The language within this rider indicates that this is for group insurance. Your TOI and Sub TOI is for an Individual Major Medical - PPO product.

Please explain.

If it is for group insurance, is there any way for you to change the TOI and Sub TOI?

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/05/2011
Submitted Date	10/05/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Thank you. I have uploaded the correct form for this individual filing.

Related Objection 1

Applies To:

- Fund Rider, ALL-RID-09.11 (Form)

Comment:

The language within this rider indicates that this is for group insurance. Your TOI and Sub TOI is for an Individual Major Medical - PPO product.

Please explain.

If it is for group insurance, is there any way for you to change the TOI and Sub TOI?

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Fund Rider	CHL-ALL-RID-09.11		Policy/Contract/Fraternal Certificate: Amendment,	Initial		40.000	CHL-ALL-RID-

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

		Insert Page, Endorsement or Rider		09.11.pdf
Previous Version				
Fund Rider	*ALL-RID-09.11*	*Policy/Contract/Fraternal Initial Certificate: Amendment, Insert Page, Endorsement or Rider*	*40.000*	ALL-RID-09.11.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Jennifer Simms

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Note To Reviewer

Created By:
Jennifer Simms on 09/12/2011 03:13 PM
Last Edited By:
Rosalind Minor
Submitted On:
10/12/2011 11:23 AM
Subject:
Cover letter 2011 09 12
Comments:
I just realize that the explanation of the form provided under Supporting Documents "cover" referenced employer partnership. As this is an individual product, that reference would not apply. However, the general concept holds true in that this Rider provides an "incentive" program to participants who engage voluntarily into wellness programs. Please disregard the employer reference made earlier.

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/12/2011	CHL-ALL-RID-09.11	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Fund Rider	Initial		40.000	CHL-ALL-RID-09.11.pdf
Approved-Closed 10/12/2011	CHL-ALL-APP-09.11	Application/Enrollment Form	Application for Coverage	Initial			CHL-ALL-APP-09.11.pdf

[LOGO]

[Coventry] [PHS] Fund Rider

This [Coventry] [PHS] Fund Rider is attached to and made part of the Coventry Health Care, Inc. Benefit Documents and is effective on the date Your Policy is effective or renews its coverage with the Plan. All definitions, terms and conditions of Your Benefit Document apply hereto unless expressly stated to the contrary in this Rider.

How Your Coventry Fund Works

Your benefit plan includes participation in the [Coventry] [PHS] Fund ("Fund"). At the beginning of Your Benefit Period, Your Fund account contains the amount specified below, plus any Fund rollover up to the Fund maximum. Your Fund account is available to reimburse You for Your costs for Deductible amounts up to the balance in Your Fund account.

Pro-ration of Your Fund Account

Your beginning balance in Your Fund account will be pro-rated for the amount of Benefit Period for which You will be enrolled. Pro-rating is calculated on a quarterly basis.

If You have a family status change during the Benefit Period, Your Fund balance will be pro-rated based on the new status. The amount, if any, in Your Fund rollover will not be adjusted as a result of this family status change.

When Your coverage is terminated, Your Fund account will be available to reimburse You up to one (1) year from Your termination date. At the end of that one (1) year period, any remaining Fund balance will revert to Us.

COVENTRY FUND*	AMOUNT
[Coventry] [PHS] Fund Balance (per Benefit Period) Individual Family	 [$0 - $10,000] [$0 - $20,000]
[Coventry] [PHS] Fund Maximum Individual Family	 [None; $0 - $20,000] [None; $40,000]
[Coventry] [PHS] Fund Rollover Maximum (from Benefit Period to Benefit Period) Individual Family	 [None; $0 - $10,000] [None; $0 - $20,000]

*Each individual will receive an amount equal to the individual Fund level, with no account exceeding three (3) times the individual Fund level per family.

Your coverage under this Rider ends when Your coverage under the Policy ends. If there is any conflict between this Rider and Your *Benefit Document,* the terms of this Rider shall control. All other terms and conditions stated in Your *Benefit Document* remain unchanged.

CoventryOne. [LOGO] Underwritten by Coventry Health and Life Insurance and administered by [Coventry Health Care of Kansas, Inc.]

[Coventry*One*]
Received Date: _____

[Health Plan Name] [Special State or Association Name]

Application for Health Coverage

Submit completed Application for Health Coverage to:
[8320 Ward Parkway, Kansas City, MO 64114]
[Fax: (866) 560-6325]

Important: Please print clearly in BLACK ink as instructed in each section. Initial and date corrections [;correction fluid is not permitted]. Read and sign the [Acknowledgements] Section.

Check all that apply:

☐ New Application [☐ Add a Dependent] [☐ [HIPAA] Guarantee Issue] [☐ Plan Benefits Increase[(at renewal only)]] [☐ Child-Only Application (under 19 years old)]

[Plan Choice

Choose one (1) plan only. [If other individuals applying for coverage wish to apply for different plans, a separate Application must be used.]

[Plan Category]	[Plan Category]	[Plan Category]	[QHDHP Plans]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Plan name]	☐ [Plan name]
☐ [Plan name]	☐ [Plan name]	☐ [Other plan name _____]	☐ [Plan name]

[Maternity benefits for this plan begin [twelve (12)] months from the effective date of the policy.]

[Network Selection [If you have selected a [Plan Category] plan, you are required to choose a network below.]]

☐ [Network name – network description]
☐ [Network name – network description]
☐ [Network name – network description]

[Health Savings Account (HSA) Selection [If you have selected a <Coventry*One*> Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, [Health Equity], upon approval. [Through [HealthEquity], [you will be subject to an account activation fee of [$1 - $30] and [monthly account maintenance fees of [$1 - $10] may apply]].

☐ **I elect to have an HSA opened through [HealthEquity]]**

[Other Option[s] The below addition[s] [is/are] optional. Please note that additional premium may apply.**]**

☐ [Addition name – addition description]
☐ [Addition name – addition description]
☐ [Addition name – addition description]

Requested Effective Date [Choose one (1) option only.] Requested Effective Date must be after, but no MORE than [sixty (60) days] past the signature date of the Application. Requested Effective Date is not guaranteed.

[☐ Day of <Coventry*One*> Approval] **[☐ ___ / ___ / _____ (mm/dd/yyyy)]** **[☐ ___ / 01 / _____ (mm/dd/yyyy)]** **[☐ ___ / 15 / _____ (mm/dd/yyyy)]**	**Amount quoted for Requested Effective Date: $_____ / Month** [☐ Individual ☐ Family] [Note: The amount quoted is an estimated cost of the selected health plan [and / or other selected options], which is subject to change based on medical history, the underwriting process, and, if any, other relevant factors.]

Primary Applicant Information

Please provide information on the Primary Applicant. [**If applying for Child-Only coverage,** please fill in the parent or legal guardian's information below.]

Last name	First name			MI	Primary phone number ( ) -
Home address	City	State	ZIP	[County]	
Mailing address *(If different from address above)*	City	State	ZIP	Best time and phone number to receive a call regarding this Application, if necessary: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime (8am-8pm) ( ) -	
E-mail address *(if we may correspond with you via E-mail)*	☐ [Check here to consent to receiving your [policy] and other pertinent documents by e-mail only]				
[Relationship *(if Child-Only Application)*]	[Occupation / Title]				

Primary Applicant Name: _____ **[Agent] Name:** _____

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. [[For a Child-Only Application], begin listing child(ren) on Line 3 with the youngest child listed first.] If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

	Full Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months?[2]	U.S. residency for past [6 months?][3]	[Primary Care Physician (PCP)[HMO only][4]]
1	**Primary Applicant** [(blank if Child-Only)]					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]							[PCP ID #]
2	**Spouse** [(blank if Child-Only)]					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]	Home address (if different from Primary Applicant)						[PCP ID #]
3	**Dependent Child [or Child-Only]**					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]	Home address (if different from Primary Applicant)						[PCP ID #]
4	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]	Home address (if different from Primary Applicant)						[PCP ID #]
5	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]	Home address (if different from Primary Applicant)						[PCP ID #]
6	**Dependent Child**					☐ Yes ☐ No	☐ Yes ☐ No	[PCP Name]
	SSN#[1]	Home address (if different from Primary Applicant)						[PCP ID #]

[[1]Not required in <State>]. [[2] 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. [3] 'U.S. residency" refers to the designated individual living [legally] in the United States for the past [6 months/2 years]. [[4] 'Primary Care Physician (PCP)' refers to the provider that you would see first for any medical problem. [For Health Maintenance Organization (HMO) products, the PCP must be within our provider network. A list of participating providers can be found at the health plan's website [www.health plan web address].] Please note that choice of PCP is not guaranteed; however, should you be accepted for coverage, you can change your PCP at any time.]

1 Prior Insurance Coverage

Has any individual applying for coverage had any health insurance coverage in the past 2 years?
If "Yes," list names, start and end dates below. ☐ Yes ☐ No

_____

2 [Pre-Existing Condition Clause]

[If applying for PPO coverage,] [Does any individual applying for coverage have proof of prior creditable coverage without a break in coverage of 63 days or more and would like to use it to credit any pre-existing condition limitation?
If "Yes," you must include a copy of the [creditable coverage document(s) / Certificate of Creditable Coverage]. [You may be subject to a pre-existing condition exclusion until <Coventry> receives these documents.] If the applicant is age nineteen (19) or older, there is a pre-existing condition waiting period. If the applicant is age eighteen (18) or younger, there is no pre-existing waiting period. ☐ Yes ☐ No

3 [HIPAA Guarantee Issue Coverage]

[**If you have answered "Yes" to the above Pre-Existing Condition Credit question, you may be HIPAA eligible and may have the right to obtain certain individual health policies on a guaranteed issue basis and without application of any pre-existing condition exclusions or limitations. You must meet ALL of the following criteria:**

- You must have had creditable coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage, other than coverage under a short-term health insurance policy, must have been under a group health plan, governmental plan, church plan or other health insurance coverage offered in connection with any such plan;
- Your coverage must not have been terminated because of fraud or failure to pay premiums;
- You must have been offered and elected COBRA or state continuation coverage and exhausted such coverage;
- You must not be eligible for a group health plan or Medicare and you must not have any other health insurance coverage.

☐ **Yes, I meet the above criteria and am applying for Guarantee Issue coverage**.

[NOTE: If not all individuals applying for coverage meet the HIPAA requirements, those who are not HIPAA eligible must complete a separate Application for Health Coverage which will be reviewed through the regular underwriting process.]]

Medical Information

The Medical Details section requires your careful attention to each question. The questions below should be answered by you and not by any broker representing you. If you fail to provide truthful or accurate health history information, <Coventry> may not issue coverage or may rerate, terminate, or rescind your coverage. You may want to consult your physicians if you have questions regarding the information requested below.

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the [Medical Details] section when necessary.

1 Physical Exam	
Has any individual applying for coverage had a physical or wellness exam within the past [6 months / 2 years]? If "Yes," provide details in the [Medical Details] section.	☐ Yes ☐ No
2 Pregnancy	
Is any individual applying for coverage [currently] pregnant [as diagnosed by a medical professional], expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child?	☐ Yes ☐ No
3 Female Health History	
3a. Has any female applying for coverage had a Pap smear/pelvic exam within the last [2 years]? If "Yes," indicate results of exam: ☐ Normal ☐ Abnormal (If abnormal, complete the [Medical Details] Section)	☐ Yes ☐ No
3b. Has any female applying for coverage had a mammogram within the last [2 years]? If "Yes," indicate results of exam: ☐ Normal ☐ Abnormal (If abnormal, complete the [Medical Details] Section)	☐ Yes ☐ No
4 Transplants	
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the [Medical Details] section.	☐ Yes ☐ No
5 HIV / ARC / AIDS	
Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	☐ Yes ☐ No

Check all that apply. In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for [by a medical professional], been advised [by a medical professional] to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised [by a medical professional] that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the [Medical Details] section.

6 Cancer / Cyst / Tumor		
☐ Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ	☐ Cyst, growth, lump, mass, tumor or polyp ☐ Other	☐ None
7 Respiratory System		
☐ Allergies or asthma ☐ Emphysema or chronic lung disease (COPD)	☐ Sleep apnea ☐ Other	☐ None
8 Cardiovascular and Circulatory System		
☐ Hypertension or high blood pressure ☐ Deep Venous Thrombosis or phlebitis ☐ Varicose veins, blood clot or aneurysm	☐ Irregular heartbeat, heart murmur, or mitral valve prolapse ☐ Heart attack, chest pain or angina ☐ Other	☐ None
9 Digestive System		
☐ Chronic abdominal pain, ulcer, acid reflux or hiatal hernia ☐ Diverticulitis, diverticulosis, hemorrhoids, or hernia ☐ Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	☐ Liver condition or hepatitis A ☐ Cirrhosis, fatty liver or hepatitis B or C ☐ Surgical treatment for obesity, gastric bypass or banding ☐ Other	☐ None
10 Emotional or Mental Health		
☐ Anxiety or depression ☐ Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder ☐ Bipolar disorder	☐ Obsessive Compulsive Disorder, schizophrenia ☐ Eating disorder ☐ Therapy or counseling ☐ Other	☐ None

Primary Applicant Name: _____ **[Agent] Name:** _____

11 Muscular or Skeletal System

- ☐ Bursitis, tendonitis or gout
- ☐ Disorder of the back, neck or spine
- ☐ Connective tissue disorder, systemic lupus, rheumatoid arthritis
- ☐ Fibromyalgia
- ☐ Disorder of the knee, shoulder, hip or other joint
- ☐ Osteoarthritis, osteoporosis or osteopenia
- ☐ Temporomandibular joint disorder (TMJ)
- ☐ Fractures or broken bones
- ☐ Prosthetic limbs or devices, or internal fixations(pins, plates, screws)
- ☐ Any chiropractic treatments
- ☐ Other

☐ **None**

12 Skin

- ☐ Acne or rosacea
- ☐ Eczema or psoriasis
- ☐ Abnormal or cancerous moles, melanoma
- ☐ Other

☐ **None**

13 Eyes / Ears / Nose / Throat

- ☐ Disease or injury of eye
- ☐ Cataracts or glaucoma
- ☐ Ear disorder, ear infections or tubes in ears
- ☐ Hearing loss or cochlear implant
- ☐ Deviated septum or sinus infection
- ☐ Disorder of the throat, tonsils or adenoids
- ☐ Other

☐ **None**

14 Kidney or Urinary Tract

- ☐ Bladder or urinary tract infection or disorder
- ☐ Kidney infection or disorder
- ☐ Kidney or bladder stones
- ☐ Other

☐ **None**

15 Female Reproductive System

- ☐ Disorder of the breast or abnormal mammogram
- ☐ Saline breast implants
- ☐ Silicone breast implants
- ☐ Abnormal Pap smear
- ☐ Endometriosis, uterine fibroids or uterine prolapse
- ☐ Infertility or complications of pregnancy
- ☐ Menopausal disorder
- ☐ Menstrual disorder
- ☐ Cervical, ovarian, uterine or vaginal disorder
- ☐ Other

☐ **None**

16 Male Reproductive System

- ☐ Infertility
- ☐ Penile or testicular disorder
- ☐ Prostate disorder, elevated PSA, Prostatitis
- ☐ Other

☐ **None**

17 Sexually Transmitted Diseases

- ☐ Chlamydia
- ☐ Genital warts
- ☐ Genital herpes
- ☐ Human Papilloma Virus (HPV)
- ☐ Gonorrhea or syphilis
- ☐ Other

☐ **None**

18 Blood / Adrenal / Endocrine / Pituitary / Thyroid

- ☐ Anemia
- ☐ Diabetes
- ☐ Elevated blood sugar
- ☐ Elevated cholesterol or triglycerides
- ☐ Endocrine, adrenal, or pituitary disorder
- ☐ Weight disorder
- ☐ Thyroid disorder
- ☐ Other

☐ **None**

19 Brain or Nervous System

- ☐ Concussion or head injury
- ☐ Migraines or chronic headaches
- ☐ Convulsions, seizures, epilepsy, fainting, tics or tremors
- ☐ Stroke, Transient Ischemic Attack (TIA) or paralysis
- ☐ Multiple sclerosis
- ☐ Other

☐ **None**

20 Congenital or Development

- ☐ Cleft palate or cleft lip
- ☐ Developmental disorder or delay
- ☐ Mental retardation, autism, or Down's Syndrome
- ☐ Other

☐ **None**

21 Alcohol / Drug

- ☐ Alcohol abuse, dependency or alcoholism
- ☐ Drug / substance abuse or dependency
- ☐ A citation or conviction for driving under the influence of alcohol or any drug / substance
- ☐ Other

☐ **None**

22 Other Conditions

In the past [2/5/10] years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for [by a medical professional], been advised [by a medical professional] to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised [by a medical professional] that they have or may have had any other condition(s) not listed on this Application? If "Yes," provide details in the [Medical Details] Section.	☐ Yes ☐ No

Medical Details

Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the [Medical Information] section. Provide the question number you are referencing in the first column. If you need more space, **attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

Medications

Please provide COMPLETE details for all medications (prescription or over-the-counter, or injectables) currently being taken or that have been taken by (including samples), or were prescribed or recommended [by a medical professional] for any individual applying for coverage in the past [12 / 24] months. If you need more space, **attach a separate sheet of paper** with the details in the same format as the box below. Sign and date any attachments.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

Primary Applicant Name: _____ **[Agent] Name:** _____

Acknowledgements

[By signing this Application form, I, the Applicant, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review [unless applying for Guarantee Issue coverage]. I understand that the selling agent (if applicable) has no authority to promise coverage to the applicant or any individual applying for coverage, or to modify Coventry's underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether [Coventry] accepts my Application and so provides me with a policy of health coverage for which I'm applying [including Guarantee Issue coverage]. I attest that my Application responses are complete and accurate to the best of my knowledge.
- I understand that if any material information is omitted or misrepresented from any section of the Application, coverage may be refused, terminated, or rescinded, at [Coventry's] sole discretion. [Coventry] may rescind coverage only in cases of fraud or intentional misrepresentation of a material fact. In the event that coverage is rescinded, the policy will be voided back to the original effective date and [all premium payments will be refunded]. [Coventry] shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify [Coventry] in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide Coventry with this updated health information may result in a change of rate, denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for [Coventry*One*] coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.

DO NOT cancel your existing health coverage until Coventry has notified you in writing that your coverage with Coventry is effective. Please retain a copy of this application for your records.]

Any person who knowlingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an Application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Primary Applicant's Signature	**Date**	**Spouse's Signature** (if applying for coverage)	**Date**
Dependent Signature[1]	**Date**	**Dependent Signature**[1]	**Date**

The below signatures must be completed [if this is a Child-Only Application or] if any child applying for health coverage (under the age of 18) has a Custodial Parent[2] **that is not the Primary Applicant or Spouse of the Primary Applicant.**

Parent/Legal Guardian Signature	**Print Name**	**Relationship to individual applying for coverage**	**Date**
Custodial Parent Signature[2]	**Print Name**	**Name of child(ren) to whom this applies**	**Date**

[1]Dependent Signature is required for individuals applying for coverage ages 18 and over
[2]The 'Custodial Parent' is the person with physical or legal custody of a child under 18 years of age.

FOR [AGENT] USE ONLY

[[**Agent**] **Certification**: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised any individual applying for coverage to withhold any information regarding the answers to the questions and have advised the individuals applying for coverage to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded in this application are correct, complete, and wholly true to the best of my knowledge and belief.]

[Agent name]	[Agent ID#]	[Agent E-mail]

Primary Applicant Name: _____ **[Agent] Name:** _____

[Agency name]	[Agent / Agency phone]	[Name of General Agent]
[Payee (who is paid commissions) ☐ Agent ☐ Agency ☐ General Agent	[Payee Tax ID#]	
[Agent Signature	**Date]**	

Premium Payment

Initial Premium Payment Option[s] [Choose **ONE** payment option for initial payment. You must then complete the applicable section regarding your account information.]

☐ [EFT] ☐ [Credit card] ☐ [Check] ☐ [Statement Billing]

Ongoing Premium Payment Options Choose **ONE** payment option for ongoing payment. You must then complete the applicable section regarding your account information.

☐ [**Monthly EFT** [(subject to [one time] Administrative Fee of [$1-$10] per subscriber / person]])] [(no administrative fee)]]

☐ [**Monthly credit card draw** [(subject to Administrative Fee of [$1-$10] per subscriber / person per month]])]

☐ [**Monthly statement billing** [(subject to Administrative Fee of [$1-$10] per subscriber / person per month]])]

☐ [**Quarterly statement billing** [(subject to Administrative Fee of [$1-$10] per subscriber / person per month]])]

☐ [**Semi-annually statement billing** [(subject to Administrative Fee of [$1-$10] per subscriber / person per month]])]

☐ [**Annual statement billing** [(subject to Administrative Fee of [$1-$10] per subscriber / person per month]])]

[Payroll Deduction Program (PDP) / Employer List Bill (ELB) This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you **MUST** submit a separate Payroll Deduction Authorization Form with your Application.]

☐ **[NEW Payroll Deduction Program (PDP) / Employer List Bill (ELB)]**	☐ **[EXISTING Payroll Deduction Program (PDP) Employer List Bill (ELB)** PDP number: _____ PDP name: _____]

EFT (Electronic Funds Transfer) Information [Complete this section if you have chosen to pay by EFT. [The first month's premium will automatically be withdrawn from the listed bank account upon acceptance.] [Thereafter,] the monthly premiums will be withdrawn automatically on the [5th / 10th] day (or next business day if a weekend or holiday) of the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the [1st] of the month, the initial premium will be prorated.]]

☐ Checking Account ☐ Savings Account	Name of account holder	9-digit routing number	Account number
Name of bank / savings institution		Relationship of account holder to Primary Applicant ☐ Self ☐ Spouse ☐ Other_____	
Account holder address		City	State / ZIP
[Token]		[Account number (Last 4 digits)]	

[Credit Card Information [Complete this section if you have chosen to pay by credit card. [The first month's premium will automatically be charged against the listed credit account upon acceptance.] If the effective date is anything other than the [1st] of the month, the initial premium will be prorated based on your effective date.]]

☐ [VISA] ☐ [MasterCard] ☐ [Discover]	[Name of card holder(exactly as on card)]	[Card number]	[Exp. date (mm/yyyy)]	[Verification code[1]]
[Card billing address]		[City]	[State]	[ZIP]
[Token]		[Account number (Last 4 digits)]		

[1 The Verification Code for your Visa or MasterCard is a 3-digit code printed near the signature strip on the back of your card.]

[Statement Billing Information [If you choose Statement Billing, your bill will be sent to the Mailing Address you supplied in the [Primary Applicant Information] section on page [1]. [At this time, we are unable to bill you at an alternate address.]]

[**Important Note:** [[Coventry*One*] is not an employer-sponsored group health plan.] If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact [us / your agent] to complete a [CoventryOne Payroll Deduction / Employer List Bill (ELB) Authorization Form].]

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to immediately notify Coventry Health and Life Insurance Company at [<insert #>] should your payment or address information change at any time while you continue to hold a <Coventry*One*> policy.
- [You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of [$20.00]. [You authorize Coventry Health and Life Insurance Company to collect the premium payment due between the [20th – 30th] of the month, including any unpaid fee amount.] Failure to remit the first payment could result in rescission back to your effective date.]
- You understand that providing this payment information does not guarantee approval or coverage.
- Upon approval and acceptance of this Application, you authorize Coventry Health and Life Insurance Company to initiate [an immediate] automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. [If your effective date is entered into the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.]
- I agree this authorization will remain in effect until I provide written notification terminating this service.

Account / Card Holder Signature:_____ **Date:**_____

Authorization of Release of Information

I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to Coventry Health and Life Insurance Company or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

The information authorized for release may include the presence of a communicable or non-communicable disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).

List of Providers For the purposes of obtaining medical records if they are required to process your Application, please provide the following information about all provider(s) that are involved in the care of any individual applying for coverage. **Please provide information for all providers, even if previously mentioned on this Application.**

Provider Name (Last, First)	Provider Address	City	State	ZIP

Primary Applicant Name: _____ **[Agent] Name:** _____

In addition, I authorize Coventry Health and Life Insurance Company to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Coventry Health and Life Insurance Company for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Coventry Health and Life Insurance Company to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Coventry Health and Life Insurance Company as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize Coventry Health and Life Insurance Company to use or disclose the information I provide in this Application (or that the Coventry Health and Life Insurance Company has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) but shall not exceed twenty-four (24) months from the date signed. Any revocation will not affect the activities of Coventry Health and Life Insurance Company prior to the date such revocation is received by Coventry Health and Life Insurance Company.

Coventry will not condition treatment, payment, or eligibility of benefits on whether the individual signs the authorization. However your application will not be underwritten unless you execute this form.

By signing this Authorization of Release of Information, I am authorizing any physician(s) and / or medical professional(s) including but not limited to those providers listed herein, to disclose the information as described above.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Primary Applicant's Signature	**Date**	**Spouse's Signature** (If applying for coverage)	**Date**
Dependent Signature*	**Date**	**Dependent Signature***	**Date**

*Required age 18 and over.

[The below signature must be completed if this is a Child-Only Application.]

[Parent/Legal Guardian Signature]	**[Print Name]**	**[Relationship to child applying for coverage]**	**[Date]**

Primary Applicant Name: _____ **[Agent] Name:** _____

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/12/2011
Comments:			
Attachment:			
FLESCH.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	10/12/2011
Bypass Reason:	n/a to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	10/12/2011
Bypass Reason:	n/a to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	10/12/2011
Bypass Reason:	n/a to this filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/12/2011
Bypass Reason:	n/a to this filing		
Comments:			

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

		Item Status:	**Status Date:**
Satisfied - Item:	Fund Rider cover 2011 09 12	Approved-Closed	10/12/2011

Comments:

This form is a new "product line" that pairs wellness incentives with a high deductible health (not qualified) plan by providing dollars towards a "savings" that can be used to off-set deductible expenses. This is a multi-year strategy benefit design intended to partner with employers to manage costs and drive behavior changes. This Rider helps communicate the "saving" ability that these incentives can provide to participants.

The brackets represent wording options that will be used exactly as depicted or removed, except numerical ranges that represent a minimum and maximum range. Address and phone numbers are bracketed as variable to be changed as needed.

COVENTRY
Health and Life Insurance Company

Certification of Flesch Reading Ease

This document herby certifies that the submitted documents, referenced below, comply with the provisions of the Life, Accident and Health Insurance Policy Language Simplification Act of Arkansas.

Any policy language is drafted to conform to the requirements of any federal law, regulation, or agency interpretation, including medical terminology, defined words, and any other policy language required by state law or regulation.

Riders, amendments, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

This certification shall accompany every and shall be signed by an authorized representative of the insurer certifying that the filing meets the minimum reading ease score on the test used.

Attested by:

Signature

Director, Regulatory Compliance, Appeals, and Product Implementation
Title

Form number(s) submitted:	
ALL-RID-09.11	Fund Rider

SERFF Tracking Number:	*CVKS-127622115*	*State:*	*Arkansas*
Filing Company:	*Coventry Health and Life Insurance Company*	*State Tracking Number:*	*49763*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Individual Forms*		
Project Name/Number:	*Application & Rider/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/12/2011	Form	Fund Rider	10/05/2011	ALL-RID-09.11.pdf (Superceded)

[LOGO]

[Coventry] [PHS] Fund Rider

This [Coventry] [PHS] Fund Rider is attached to and made part of the Coventry Health Care, Inc. Benefit Documents and is effective on the date Your Group is effective or renews its coverage with the Plan. All definitions, terms and conditions of Your Benefit Document apply hereto unless expressly stated to the contrary in this Rider.

How Your Coventry Fund Works

Your benefit plan includes participation in the [Coventry] [PHS] Fund ("Fund"). At the beginning of Your Benefit Period, Your Fund account contains the amount specified below, plus any Fund rollover up to the Fund maximum. Your Fund account is available to reimburse You for Your costs for Deductible amounts up to the balance in Your Fund account.

Pro-ration of Your Fund Account

If You are not enrolled in Your Group's benefit plan at the beginning of the Benefit Period or in the event You are rehired within the Benefit Period, Your beginning balance in Your Fund account will be pro-rated for the amount of Benefit Period for which You will be enrolled. Pro-rating is calculated on a quarterly basis.

If You have a family status change during the Benefit Period, Your Fund balance will be pro-rated based on the new status. The amount, if any, in Your Fund rollover will not be adjusted as a result of this family status change.

When Your coverage is terminated, Your Fund account will be available to reimburse You up to one (1) year from Your termination date. At the end of that one (1) year period, any remaining Fund balance will revert to Us.

COVENTRY FUND*	AMOUNT
[Coventry] [PHS] Fund Balance (per Benefit Period) Individual Family	 [$0 - $10,000] [$0 - $20,000]
[Coventry] [PHS] Fund Maximum Individual Family	 [None; $0 - $20,000] [None; $40,000]
[Coventry] [PHS] Fund Rollover Maximum (from Benefit Period to Benefit Period) Individual Family	 [None; $0 - $10,000] [None; $0 - $20,000]

*Each individual will receive an amount equal to the individual Fund level, with no account exceeding three (3) times the individual Fund level per family.

Your coverage under this Rider ends when Your coverage under the Group Agreement ends. If there is any conflict between this Rider and Your Group Agreement or the *Benefit Document,* the terms of this Rider shall control.

All other terms and conditions stated in Your *Benefit Document* remain unchanged.